"A True 'Doctor's Dilemma'"

From Dr. F. M. Parsons, Consultant in Clinical Renal Physiology, The General Infirmary at Leeds

Recent publicity in the press and on the radio and television has spotlighted one relatively small facet of medical practice and ethics—namely, the selection of patients for treatment by intermittent dialysis. It is undeniable that this form of therapy is excellent for the carefully selected patient, but at the moment there is one insuperable snag. Facilities are not available for all, and this situation is likely to be so for a considerable period of time—while the cost (about £1,500 per annum) is beyond the private means of most people. Unfortunately, moreover, the very publicity that alerted the medical profession, the Ministry of Health, and the public to the value of intermittent dialysis is now having a boomerang effect, for the pressure being applied to existing units to increase their work load is great and may reach breaking point. This must be resisted strenuously lest the life of both the new patient and those that have been treated for months or years be endangered. The recent outbreaks of hepatitis in some units serves only to reinforce this argument, if indeed this was necessary.

The selection of the few is proving very difficult—a true "Doctor's Dilemma"—for almost everybody would agree that this must be a medical decision, preferably reached by consultation among colleagues. Some patients are unsuitable on strictly medical grounds, such as coexistent disease; these decisions are easy and are readily accepted. But what about the other patients who are suitable medically but for whom no facilities are available? The indications could be tightened; though this is contrary to our ethical code, it appears to be the only practical solution at the moment. Even so, it is apparent that a "game of chance" still exists, since any vacancies will be filled immediately by the first suitable patients, even though their claims for therapy may subsequently prove less than those of other patients referred later.

In an attempt to overcome some of these difficulties in selection some have advocated introducing certain specified lay-people into the discussions. Is this wise? I doubt whether a committee of this type can adjudicate as satisfactorily as two medical colleagues, particularly as successful therapy involves close co-operation between doctor and patient. Such co-operation may be disturbed if it is known that a lay committee has been responsible for the final selection. Nevertheless, in order for doctors to reach the best decision some discussion with lay-people may sometimes be essential.

The social aspects created by this new form of therapy must never be ignored, and much has still to be learnt. The hospital social workers are of great value, for they are experienced in collecting the initial data about the patients and their home surroundings; later they may be called upon to help if social difficulties arise. Looking further ahead, we must consider other social aspects. For instance, many patients who satisfy the medical requirements for intermittent dialysis may be employed in unsuitable occupations. Co-operation between the medical staff of rehabilitation centres and specialists in renal disease is vital at an early stage of the illness so that suitable alternative employment may be found and training given to patients before they need haemodialysis. Gainful employment in a well-chosen occupation is necessary to achieve the best results; only the minority wish to live on charity.

Today many genuine excuses for our inability to treat all suitable patients exist—shortage of staff, accommodation, and apparatus are too apparent—but it must be remembered that this is not unusual even in non-medical spheres when a new procedure is introduced. Nevertheless, this new form of therapy creates an unparalleled precedent, as therapy is both expensive and continuous. The expectation of life of the patient treated by intermittent dialysis is unknown at the moment, but the percentage who have lived longer than five years may well be found to exceed that of some other incurable diseases.

The need for long-term planning is clear, but who is to take the final responsibility? Clearly this must be the community, and the full facts must be presented. Economics cannot be ignored, for establishing a comprehensive dialysis service will eventually reach an annual cost of several million pounds, since it has been estimated that at least 30 new patients per million of the population will be seen each year. Should the community decide that this form of therapy has to be introduced then the profession must insist that other medical services—some perhaps more vital to the community—must not be curtailed. If the community decides to treat every suitable patient then this inevitably means either a corresponding increase in national wealth or (if this does not materialize) a little bit less for every member of the community. The implications must be clearly stated and a policy laid down, while the profession and industry (who will supply the apparatus) must be informed.

F. M. PARSONS.

Surgeon's Point of View

From Professor Ralph Shackman, Professor of Urology, Royal Postgraduate Medical School, London

In a civilized society few would deny the principle that it should be obligatory for us to provide optimal care of the sick. But many would feel that there is ultimately an economic limit to practical fulfilment of such an ideal. This is the background of the dilemma we now face in respect of selecting patients for long-term haemodialysis.

Doctors should be able to mete out to all alike services worthy of the Hotel Dieu, asking no questions in regard to race, creed, age, or character, and proscribing no judgement other than medical. But we cannot do so, for we know that several thousand patients die from renal failure each year in the United Kingdom and—for some time to come at least—we can treat only about ten per cent. of them by long-term haemodialysis. When there are no more facilities there is an unintentional, but nevertheless definite, selection against subsequent applicants for dialysis treatment. This form of selecting patients is justified on the grounds that we as doctors are doing as much as we can within the available financial resources of the State. But other forms of selecting patients are suspect in my view if they imply evaluation of man by man. What criteria could be used? Who could justify a claim that the life of a mayor would be more valuable that that of the humblest citizen of his borough? Whatever we may think as individuals none of us is indispensable. On the other hand, to assume that there was little to choose between Alexander Fleming and Adolf Hitler as beneficiaries of their fellow men and women would be nonsense, and we should be naive if we were to pretend that we would not be influenced by their achievements and characters if we had to choose between the two of them. Whether we like it or not we cannot escape the fact that this kind of

Br Med J: first published as 10.1136/bmj.1.5540.623-a on 11 March 1967. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

selection for long-term haemodialysis will be required until very large sums of money become available for equipment and services.

Who is to implement the selection ? In my opinion it must ultimately be the responsibility of the consultants in charge of the renal units that are established, or are to be established, up and down the country. For when a patient is referred by a doctor to such a unit, and there is a vacancy on their long-term haemodialysis programme, it is to be expected that those doctors who have had special experience or training in such units would be better able to rationalize a decision, one way or the other, than those less aware of the specific medical, surgical, and administrative problems involved. Moreover, they could reasonably be expected to know the place of alternatives such as kidney transplantation. Referral of patients is traditional in British medicine, and a second opinion in a difficult case is well understood and generally appreciated by all concerned. There should be no reason why such well-accepted methods should not work in the difficult case of selection of patients for long-term haemodialysis. Profound domestic and social problems are apt to be produced by any serious illness, and the experienced doctor is dealing with them virtually every day of his professional life. Selection of patients for long-term haemodialysis is just another challenge for him, and if he is worth his salt he is less likely than most to be influenced by emotional circumstances. I can see no justification for delegating this responsibility to lay persons. Surely the latter would be better employed if they could be persuaded rather to devote their time and energy to raise more and more money for us to spend on our patients.

RALPH SHACKMAN.

Doctor's Duty to His Patient

From Dr. M. A. Wilson, General Practitioner, Huntington, York

Haemodialysis is now established as a valuable adjunct in the treatment of renal failure, yet haemodialysis units are not generally available, and where they are provided they are not large enough to cope with all the patients who might benefit from haemodialysis. The Minister of Health is under pressure to provide units throughout the country, for he is charged by the community to provide a comprehensive health service. Nevertheless, the Minister, as agent for the community, has the responsibility to deploy the available resources to the best advantage, and has always to be concerned with the general consequences of individual decisions. Hence the decision to provide further dialysis units must be made in the light of the other needs of the National Health Service. A doctor's prime responsibility, on the other hand, is to his patient, so that the patient may be restored to the highest standard of physical and mental health he can attain. If a doctor believes his patient will benefit from haemodialysis he must do his utmost to provide the necessary treatment.

In the period before units are generally available decisions have to be reached on the suitability of patients for dialysis and which of those suitable shall be dialysed. It would seem reasonable that patients with any potentially reversible condition should be treated first. The main difficulty lies in selecting the next patients to be treated. A doctor faced with choosing which individuals to dialyse from a group of patients with chronic renal failure has a collective responsibility to the group to do his utmost to provide haemodialysis for all who would benefit. Hence it is essential that haemodialysis is seen to be a successful form of treatment for chronic renal failure, and the individuals chosen should be those who will benefit most, thereby also achieving the greatest good. I think this is a clinical decision to be taken by the doctor in charge in consultation with his colleagues.

The suggestion has been made that lay panels should select individuals for dialysis from among a group who are medically suitable. Though this would relieve the doctor-in-charge of a heavy load of responsibility, it would place the burden on those who have no personal knowledge of the patients and have to base their judgement on medical and social reports. I do not believe this would result in better decisions for the group or improve the doctor-patient relationship in individual cases. If the doctor advises dialysis and the lay panel refuses the patient will regard this as a death sentence passed by an anonymous court from which he has no right of appeal ; this will create great difficulties in the patient's future management. If cases are considered by the panel without the patient's permission or knowledge uncertainty would be engendered in the minds of all patients under the doctor's care about whether they had been referred to the panel, or referred and refused. For the individual patient treatment does not begin or end with the decision to advise dialysis. This is an adjunct to the treatment of renal failure which may prolong life for a considerable time, but if dialysis is not used treatment will continue along the usual lines.

I believe it is our duty to attain the best possible state of health for our patients, and that this must always be taken into account when making decisions which determine the advice we give to our patients. The final decision will be made by the patient.

M. A. WILSON.

Br Med J: first published as 10.1136/bmj.1.5540.623-a on 11 March 1967. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.